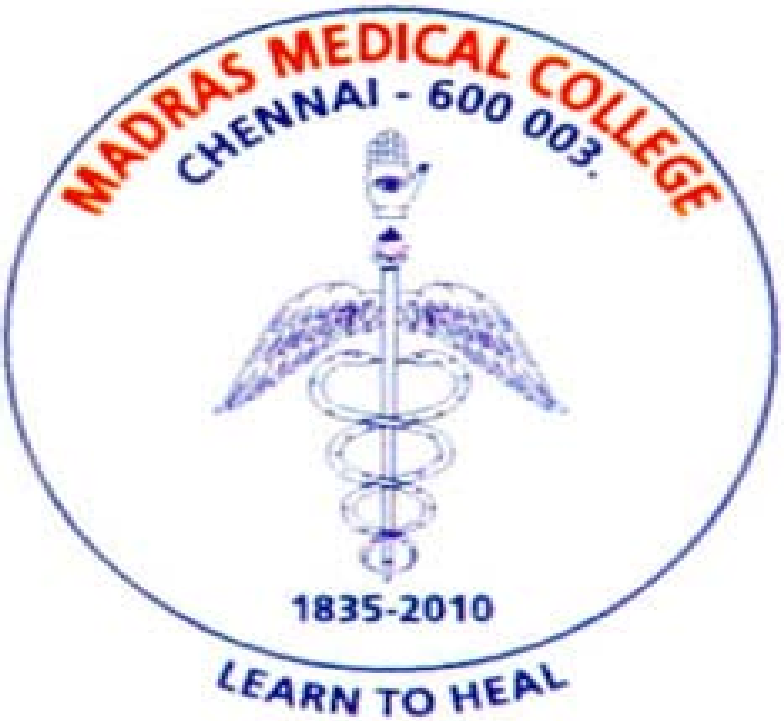
CASE RECORD



APRIL 2012 SESSION

CERTIFICATE

This is to certify that this work titled “CASE RECORD” submitted by Dr. M. DEVAGI as a part of fulfilment of the requirements for the Diploma in Psychological Medicine course of The Tamil Nadu Dr. M.G.R Medical University is an original and bonafide work.

Unit Chief
Unit II, IMH
Kilpauk

Head of Department
IMH, Kilpauk
Dean
Madras Medical college
Chennai-600003

ACKNOWLEDGEMENT

I sincerely thank Dr. V. Kanagasabai M.D, Dean, Madras Medical College for his support and encouragement to help me complete this case record as a part of completion of Diploma in Psychological Medicine course.

I am deeply indebted to thank Prof. Dr. Kumar, M.D., D.P.M Director of Institute of Mental Health, Kilpauk for his never ending support and guidance in completion of this case record.

I am grateful to Prof. Dr .Kumar, M.D, D.P.M Unit I chief, for being a source of motivation and inspiration.

I also thank Department of Psychology, I.M.H for their valuable reports which guided us in the treatment of all the patients.

Finally I would like to extend my gratitude to the patients and their family members who cooperated for history taking.

INDEX

CASE - I

Name	:	Mr. R
Age	:	24 yrs
Sex	:	Male
Education	:	Bsc (Maths), discontinued
Occupation	:	Unemployed
Reglion	:	Hindu
Socio economic	:	MSES
Informants	:	Elder sister, mother
Information	:	Reliable, Adequate and inconsistent

REASONS FOR CONSULTATION:

Sleep disturbance Compulsive ritual acts	4years
Suspiciousness Abusive & assaultive Neglecting self-care	2years
Suicidal attempt Self harm injurious behavior	1½ years

Insidious onset, continuous illness and progressive in nature.

HISTORY OF PRESENTING ILLNESS:

Mr. R was reported to be normal 4 years back, he was found to be preoccupied and not communicating well with his family members and preferred to stay alone. He was talking and laughing to self. When asked he said that he heard voices speaking to him and he were replying to it. Gradually his sleep decreased and he would sleep only for 3 to 4 hours at night. He did not attend classes. He was started washing his room many times. He was taking bath frequently.

He was started worshiping god Anjanaya many times a day and also avoiding to speak with female family members. This continued for 2 months after which he started to be abusive and assaultive others for no reason. So he was taken to a psychiatrist, was admitted for 10 days and treated with ECT. After discharge he would discontinue medications on and off during which his symptoms would get exacerbated. He continued his studies but performance was poor.

He also exhibited suicidal gestures on three occasions in the form of cutting his harms and carrying kerosene and matchbox inside the bathroom, saved by family members. Again the mother took him to psychiatrist and continued medication the symptoms were under the control. He completed his course but did not complete his studies. Then

he got employment into Ford Company, his performance was average, he continued his job for 5 months with medication. After discontinue of treatment he became self withdrawn, slowly he was neglecting self care, attempted suicide , coworkers informed to his parents. Hence he was brought to IMH and admitted.

No H/O sad mood, crying spells

No H/O tall claims, spending spree

No H/O thoughts being known to others or withdrawn

No H/O substance use

No H/O head injury, LOC, seizures

No H/O fever or any prolonged drug intake.

PAST HISTORY:

No H/O any psychiatric illness in the past

No H/O diabetes, tuberculosis, asthma

FAMILY HISTORY:

Father separated from mother – 20 years ago.

He was born of 3rd degree consanguineous marriage.3rd of three siblings.

H/o mental illness probably psychotic in maternal uncle

H/o alcohol dependence in father.

PERSONAL HISTORY:

He was born out of full term normal delivery. Normal developmental milestones. Peer group inter relationship was good. Started going to school at 5 years of age. Had average scholastic performance. Completed his studies.

Started going to job at the age of 23 years.

No substance abuse.

No h/o exposure.

PREMORBID PERSONALITY:

He was introvert, shy, not responsible, preferred to be alone and had few friends. His hobbies were reading Tamil magazines. Features were suggestive of schizoid traits.

PHYSICAL EXAMINATION:

Conscious, ambulant

Moderately built and nourished

BP – 120/70 mm Hg

PR-80/ min

CVS – S1, S2 heard

RS- NVBS heard

Abdomen –Soft, nontender, No organomegaly

CNS –Clinically normal

Fundus – normal

MENTAL STATUS EXAMINATION:

General appearance, Behavior and attitude:

An alert, ambulant male, who looks appropriate for his age entered into the room by his mother. Dressed adequately. Unclean and unkempt. Gaze avoidance was present and rapport established with difficulty. Took long time to answer to questions. Partially cooperative but interested in the interview. Would get up and go away if probed about his behavior. Posturing was present.

Psychomotor activity reduced

Speech :

Quantum and tone reduced

Reaction time prolonged

poverty of speech present

Thought :

Stream- reduced

Form- sometimes irrelevant

Content :

1. Revealed ideas of persecution

Perception :

No abnormalities elicited

Mood :

Sub- Fine

Obj-Restricted, No lability

PRIMARY MENTAL FUNCTIONS:

Conscious

Attention : arousable

Concentration: ill sustained

Oriented to time, place and person

Memory :

Immediate, recent and remote – Intact

Inteligence: Impaired

General fund of information – not adequate

Arithmetic ability good

Abstract thinking impaired

Judgment:

Social and hypothetical situation impaired

Insight: Grade I

DIAGNOSTIC FORMULATION:

24 yrs old male presenting with complaints of 4 yrs duration of sleep disturbance, suspiciousness , abusive and assaultive behavior, neglecting self care, Family h/o mental illness in maternal uncle, Premorbid traits: introverted, shy, not responsiple, not adjustable, quarelsome, wants to be alone, General examination: vitals stable, CVS S1, S2 heard, RS- NVBS, no added sounds, CNS-NAD, MENTAL STATUS EXAMINATION: General appearance, Behavior & attitude: an alert,

ambulant male, dressed adequately, uncleaned, unkempt, gaze avoidance present, not intrested in interview, Rapport established with difficulty, Psychomotor activity -reduced, Speech –Quantum, Tone Rate -reduced, Reaction time- prolonged, Thought- Form-tangiality, stream-reduced, Content- ideas of persecution, Mood-Euthymic, Affect-Resricted, Higher mental function: Concsious, Attention: Arousable, Concentration: Ill sustained, Memory-immediate, recent, remote-Intact, Inteligence-Impaired, judgment-Impaired.Insight-Grade-I

PROVISIONAL DIAGNOSIS:

ICD 10 F20.3-undifferntiated schizophrenia

INVESTICATIONS:

Blood WNL

ECG -normal

EEG – normal

Chest X – ray – NAD

CT Brain – normal study

PSYCHOMETRY:

Mr.R., an unmarried person with long duration of mental illness on Irregular psychiatric treatment was assessed with following psychological tests.

TESTS ADMINISTERED:

1. SAPS – scale for assessment of positive symptoms
2. SANS scale for assessment of positive symptoms
3. PANSS – positive & negative symptoms scale
4. Rorsach ink blot test

TEST FINDINGS:

Psychological testing brought out mild amount of positive symptoms in the area of referential thinking and persecutory ideas with moderate to severe amount of negative symptoms suggestive of gross psychopathology.

SUMMARY:

He has symptom of psychosis predominantly negative features on various tests suggesting that patient is suffering from schizophrenia – undifferentiated type.

FINAL DIAGNOSIS:

ICD – 10: F 20.3 Undifferentiated schizophrenia.

MANAGEMENT:

PHARMAGOLOGICAL:

Patient is on

T. Risperidone 2mg (1-0-1)

T. Lorazepam 2mg (0-0-2)

PSYCHOLOGICAL:

Psycho education to the family emphasizing the importance of drug compliance.

At present, he is highly distributed. Therefore, psychological interventions are not much of help at present. However, Supportive psychotherapy and Occupational therapy is of help to divert his talks and thoughts into useful activities.

CASE - II

Name	:	Mr. G.
Age	:	27 yrs
Sex	:	Male
Education	:	seventh STD
Occupation	:	Electrician
Socio economic status:		LSES
Religion	:	Hindu

REASONS FOR CONSULTATION:

Tobacco consumption	:	10 yrs
Alcohol consumption	:	7 yrs
Daily drinking	:	4 yrs
Early morning drinking	:	2 months
Cannabis abuse Sleep disturbances, Excessive speech, Boasting		1 ½ months back
Abusive & assaultive behavior	:	2 weeks

Informants: Wife

Information: Reliable, Adequate and consistent

Onset: insidious, course: continuous, progressive

HISTORY OF PRESENTING ILLNESS:

The patient was introduced to using betelnut along with his friends around 18 years of age. Later be continued to use tobacco in the form of Panparag, Hans, Shanthi betelnut 4-6 packets per day. Later after 3 years of tobacco intake, he started consuming alcohol for the first time along with his friends on some occasion, he consumed beer around 200ml. As he enjoyed the high produced by the drink, he continued to take alcohol at regular interval.

After 1 year of beginning alcohol intake, he got married, after 6months of marrige life he started consuming alcohol in the form of brandy almost everynight. He would become intoxicated, come home, abuse and assault his wife frequently. Due to frequent marrital dishormony his wife left and living with her grand parants for past 8 months.

Now according to his be continued to drink alcohol, but the past two months he was engaged in some temple work, where he is

supposedto have been introduced to cannabis.After consuming cannabis, his behavior became unmanageble. He frequently keep standing in the middle of the road and appear to make gesturesas if regulating the traffic.

He would keep talking excessively and laugh for unprovoked reasons. His sleep patterns also worsened. All through out the night he would keep wandering in the street.

And also he was started talking irrelevantly and would not be able to brought back home. He would also talk high about himself. He would claim himself to be God and capable of doing lot of things and able to grant wishes to all people.

His selfcare also deteriorated, he started picking up quarrles and assaulted others. Nighbours made complaint against him. So, the family members brought him in the confused state to IMH. He was treated with Ing. Lorazepam 4 mg IM stat and referred to GGH for favour ofadmission and rule out other causes of delirium. He was treated at GGH for one week with Inj. Haloperidal 5 mg, Inj. Lorazepam 4 mg im, Inj.Thiamine and has been referred to IMH for further management.

No h/o head injury/LOC/seizures

No h/o low mood/crying spells/suicidal attempts

No h/o hearing voices

No h/o repititive washing/cheeking ect,

PAST MEDICAL HISTORY:

No similar psychiatric illness in the past

Epilepsy – 16 yrs of age – treated

Not known case of Branchual asthma/ tuberculosis

FAMILY HISTORY:

No h/o similar psychiatric illness in the family

H/O Alcohol dependence in father and two elder brothers

No h/o Abscand/suicide in the family

No h/o congenital anamalies/ Mental retardation

PAST PERSONAL HISTORY:

Early childhood history was not known

Born of consanguineous marriage

2^{nd} by birth order out of 3 siblings.

No Milestone delay.

Peer group inter relationship was good.

Started schooling at the age of 5 years, scholastic performance- poor.

Not regular to school. Staudied upto seventh standard.

Started to going to job at the age of 17 years, intially he was assessing in the electrical shop to his father.

Married at the age of 21 yrs, separated for past 8 months.

No extra/premarrital contact.

Tobacco -10 years, Alcohol consumption - 7years

CANNABIS Abuse – 10 yrs back & 1½ months back

PERSONALITY TRAITS:

Extravert, Adjustable and Easy going

Tolerant to criticism, responsible at home and also in work, He handled money and financial matters without other's help, able to maintain family relationship, religious.

PHYSICAL EXAMINATION:

Thin built, moderately nurished,

not anemic,

noicterus,

no pedal edema

Pulse -72/min

BP – 120/80 mm Hg

CVS – S1, S2 heard

Abdomen – Soft, nontender, No organomegaly

CNS :

Motor system: normal

Sensory system: normal

Autonomic function- normal

Lobar function- normal

Cerebellar function- normal

MENTAL STATUS EXAMINATION:

General Appearance and Behavior:

Alert, ambulant, thin built, adequately dressed, unkempt, not co operative for Interview, frequently changing his posture & getting up and

going out of interview room, gaze contact made ill sustained , rapport established with difficulty, tremor on outstretched hands.

Psychomotor Activity – normal

Speech :

Quantum, Tone, Rate – decreased

Reaction time – increased,

relevant at times drifts to irrelevantly,

spontaneous excessive speech

Mood –Elated

Affect - cheerful , appropriate, no lability,

Thought :

Form – Flight of ideas+

Stream- increased

Content:

1. Delusion of persecution
2. Delusion of infidelity,

3. Delusion of reference,
4. ideas of inflated self-esteem
5. grandiose ideas,

Perception :

Second person auditory hallucination

COGNITIVE FUNCTIONS:

Conscious

oriented to time and place and person

Attention & concentration:

aroused and ill sustained

Memory :

recent, remote and immediate memory is – impaired

Intelligence :

Impaired

Judgment :

Impaired

Insight :

Absent, Grade-I

PROVIONAL DIAGNOSIS:

1. DUAL DIAGNOSIS:

a. F 30 Manic episode

F30.2 Mania without psychotic symptoms

b. F19. Mental and behavioral disorders due to multiple drug use and use of other psychoactive substances.

F 19.2 Dependence Syndrome

2. F 19: Mental and behavioral disorders due to multiple drug use and use of other psychoactive substances.

F19.21 Currently abstinent, but in a protected environment

F19.5 Psychotic disorder

F19.55 Predominantly manic symptoms

PSYCHOLOGICAL ASSESSMENT:

Mr.G. was taken up for psychological, interpersonal difficulties and to aid in diagnosis.

TESTS ADMINISTERED AND THEIR RATIONALE:

1. **CAGE questionnaire :**

   It is a screening test to identify the alcoholic abuse

2. **Michigan alcohol screening test (MAST) :**

   Used to assess alcohol use and Alcohol use related disabilities

3. **Inventory of drug taking situations(IDTS) :**

   Used to assess situations which trigger heavy drinking and used to better understand relapse episodes in Individuals

4. **Eysneck's personality Questionnaire:**

   It was used to assess the different dimensions of his personality

5. **Sentence completion Test:**

   It was used to elaberate on his attitude towards family, parents, his interpersonal and hetero sexual relationships.

6. **Thematic Apperception Test:**

   It is a projective test of personality used to assess his interpersonal relationship, goals and conflicts.

7. Rorschach test:

It is a projective test of personality used to assess his personality structure and diagnosis.

8. Young's mania Rating scale:

It was used to assess the seventy of mania

BEHAVIORAL OBSERVATION:

The patient has to be repeatedly asked to sit as he was preparing to leave. He said that he was alright and has many jobs to complete. Content of the talk revealed inflated self esteem and grandieous abilities.

TEST FINDINGS:

EPQ shows that he is an extrovert with signicant scores on neuroticism also. He scored signicantly on lie scale indicating that he has certain internal conflicts.

On the sentence completion test, he has positive attitude towards his family members. He expressed confidence that he could overcome misfurtune in life. He perceives himself as a highly capable person.

On TAT, patient's descriptions were poetic, significany clang associations and rhyming tendencies were noted. He projected him as an

hero in the stories and also of his grandeous abilities. Some of his themes were aggressive and others reflected his optimism. The descriptions are of good lenth.

On Rorschach, the members of responses were noted to be excessive. He concentrates more on minute details, and his touch with reality is impaired as shown by reduced popular responses. Content analysis shows aggressive and impulsive nature.

His scores on young's mania Rating scale shows that he is hyperverbal, elated, hyperactive and irritable. He has significant sleep disturbance and grandeose ideas. He has poor judgment. He has severe manic symptoms.

InCAGE questionnaire reveals that he was dependent on alcohol, guilt about his drinking, easily annoyed by people, unable to cut down his drinking.

On IDTS he drank heavily when he was depressed in general, he felt shaky, sick or nervous and when he had trouble sleeping and relive somatic pain.

SUMMARY:

He suffered from alcohol dependence syndrome, and has predominant manic symptoms as seen on various tests indicating that the patient is suffering from mood disorder currently mania.

DIAGNOSTIC FORMULATION:

Mr. G. 27 yrs old male, studied up to 7th std married , separated for 8 months , Electrician by occupation, Hindu, Tamil speaking from low socio economic status, has been brought with c/o tobacco consumption - 10 yrs, Alcohol consumption:7 yrs, Daily drinking:4 yrs , Early morning drinking:2 months, Cannabis abuse:11/2 months back, Sleep disturbances, Excessive speech, Boasting, Abusive& assaultive behavior:2 weeks, Insidious in onset, Continuous illness, progressive in nature. First episode. Past history: Epilepsy – 16 yrs of age treated, family history: father and his two elder brothers are alcohol dependent, no deviant personality traits; physical examination: sialorrhoea +: MSE: Not cooperative, rapport established with difficulty. PMA: N, Speech: quantum, tone- decreased, reaction time- increased, relevant at times drifts to irrelevancy, spontaneous excessive speech, delusions of persecution, delusion of infidelity, delusions of reference, ideas of inflated self esteem, grandiose ideas, Perception:2nd person auditory

hallucination + , Mood: elated, Affect: cheerful. HMF: Attention concentration: ill sustained, oriented, Memory, intelligence, judgment-impaired, Insight- absent, Grade- I

INVESTICATIONS:

Blood investigations- normal

CT – Brain- normal

EEG – within normal limits

FINAL DIAGNOSIS:

DIFERENTIAL DIAGNOSIS:

1. DUAL DIAGNOSIS:

a. F 30 Manic episode

F30.2 Mania without psychotic symptoms

b. F19. Mental and behavioral disorders due to multiple drug use and use of other psychoactive substances.

F 19.2 Dependence Syndrome

2. F 19: Mental and behavioral disorders due to multiple drug use and use of other psychoactive substances.

F19.21 Currently abstinent, but in a protected environment

F19.5 Psychotic disorder

F19.55 Predominantly manic symptoms

MANAGEMENT:

PHARMACOLOGICAL:

Treatment the medical illness

Detoxification

Benzodiazepines –diazepam 5 mg HS

T. Quetiapine (50mg) 1 – 0 – 1

T. Sodium Valproate (200 mg) 2 – 1 – 2

ECT 5 sittings

FAMILY COUNSELLING:

Family counseling to provide awareness to the family members about the risk of the relapse, family members must learn not to protect the patient from the problem caused by alcohol. Otherwise, the patient may not be able to gather the energy and motivation necessary to stop the alcohol.

Importance of follow – up is stressed monitor the condition of patient and to help the family members in dealing with the patient adequately.

REHABILITATION:

Continued effort to increase and maintain high levels of motivation for Abstinence. Work to help the patient readjust to a lifestyle free of alcohol. Relapse prevention.

SELF HELP GROUPS:

Members of AA have help available 24 hours a day, associate with a sober peer group, teach that it his possible participate in the social participate in the social functions without drinking, and are given a model of recovery by observing the accomplishments of sober members of the groups.

CASE - III

Name	:	Mrs. L
Age	:	42yrs
Sex	:	Female
Marital status	:	Married
Religion	:	Hindu
Education	:	7th STD
Socio economic	:	LSES
Informants	:	Self, Husband
Information	:	Reliable, Adequate and consistent

REASONS FOR CONSULTATION :

Suspecting that her co-tenant doing harm against her -2years

Claiming that her house owner is love with her - 1year 8months

Insidious onset, progressive course,

no obvious precipitating factors

2nd psychiatric consultation

HISTORY OF PRESENT ILLNESS :

The patient was reported to be normal till one year eight months back. She claimed hat her co-tenant Mr. V called her for sexual relationship and she refused after that she started telling that he is setting people against her to harm her and also setup prostitutes as a co-tenants, to move her away from the place She also says that he tried to kill her with ambulance 108 and milk van by using his political influence.

Patient gave complaint in nearby police station about Mr. Enquiry done. But the police Also turned against her by his political influence. So, she used to go to SP office, collector office daily and shout to arrest Mr. V.

Mean while she vacated that house and shifted to Mr. S house who is friend of her brother. He is a widower, living alone. After 2 months of shifting to new house she started believing that the house owner was deeply loved with her whom she understands by his Gestures. And he did not admit his love for her has he did not want others to know. She was fought with the co-tenant once for silly reason. They were assaulted her with an aluminum mug and broken house hold article. And she assumed that Mr. V. only arranged them to fight with her.

And also without any reason the patient was fought with the female Co-tenants whoever talking to Mr. S. She uses to tell everybody that the Mr. S. loves with her. The house owner warned them to vacate the house. But she did not vacate the house. The house owner slowly cut power supply, water supply to her portion. After 4 months she vacated the house to Next Street.

Even after vacating, patient goes to Mr. S. house and starts quarrel with the new tenants that they should vacate and only because of them he is avoiding her. Every day she was going to her old house and tells everybody that the house owner loves with her. The husband told her not to go there, but she poured kerosene on him and try to kill him.

So, the house owner filed a case against her, she was arrested and kept in observation at IMH. During observation she was continuously blaming the old co-tenant that all because him only it happen. Still the house owner his loves with her, she also loves him deeply.

PAST HISTORY :

No history of similar illness in the past.

No history of seizures or fever.

No history of Hypertension or Diabetes Mellitus.

No history of substance abuse.

H/o head injury 1 year back due to assault by neighbour.

H/o hospitalization for suicide attempt 10 years back for marital conflict (by firing herself)

FAMILY HISTORY :

No h/o of mental illness

No h/o suicide or missing members in the family.

No h/o substance abuse in the family

No h/o congenital anomalies, mental retardation in the family

PERSONAL HISTORY :

Born of consanguineous marriage. Sixth by birth order out of six siblings.

No milestone delay. Fully immunized.

Started schooling at the age of five years.

Average scholastic performance. Regular to school.

Studied up to 5^{th} std, not able to continue her studies due to financial crisis.

Peer group relation was good.

Attained menarche at the age of 13 years , regular cycle.

Started working as a helper in Banyan Company on weekly wages.

Married at the age of 21 years. No children.

No extra/pre marital contact.

Sexual history not satisfactory.

PERSONALITY TRAITS :

Extravert, adamant, irritable, often hostile, responsible person, religious and not able to Maintain family relationship.

PHYSICAL EXAMINATION :

Well built, not anemic, not jaundiced, no pedal edema.

Pulse - 86/min

BP – 140/90 mm Hg

CVS – S1, S2 heard.

RS – NVBS heard.

Abdomen – Soft, non tender, No organomegaly

CNS – Clinically normal.

Fundus – normal

MENTAL STATUS EXAMINATION :

General Appearance and Behavior :

Conscious, ambulant, adequately dressed, Co-operative for interview, no tics/mannerisms.

Psychomotor Activity – normal.

Talk :

Quantum, tone rate- normal

Reaction time –normal.

Relevant & coherent.

Prosody maintained

Mood :

(s) Feels relaxed (o) Euthymic

Thought :

Form- normal

Stream-normal

Content :

1. Delusion of love :

   (Patient says that the house owner loves with her because of others he did not admits her love)

2. Delusion of persecution :

   (Patient says that the co-tenant doing harm against her)

3. Delusion of misinterpretation :

   (Patient says all bad events are created by Mr. V.)

Perception :

No perceptual disturbance.

COGNITIVE FUNCTIONS :

Conscious

Orientation :

Oriented to time and place and person.

Attention & Concentration :

Normally aroused & sustained

Memory :

Immediate, recent, and remote memory - intact.

Intelligence : Intact

Judgment : Intact

Insight :

Absent & Grade I

PROVISIONAL DIAGNOSIS :

ICD 10 – F 22. 0 Delusional disorder.

DSM IV – 297. 1 Delusional Disorder, mixed type.

PSYCHOLOGICAL ASSESSMENT :

Behavior observation :

Eye contact maintained rapport established. Talk –answers relevantly and Coherently. Content of talk –paranoid delusion and delusion of love present. Attention could be Aroused and sustained. Patient able to comprehend instructions.

Content of talk-Paranoid delusion+, Vallinathan is deliberately harming her, as he called her for sexual relationship which she refused. Created situation where she was made to vacate the house. Vallinathan made her husband alcoholic. He cut the water supply, current supply and cable connection. He is trying to plot against her. Sachinadhan is her house owner has respect, he like her. As he has a keep Radha and because of Radha, he made complaint against her and got her admitted in IMH.

TEST FINDINGS :

B. G. T shows poor visuo-perceptual gestalt functions.

On S. S. I scores are elevated on Paranoid scale.

RORSACHACH :

Psychopathology ting scale shows primary full delusions of systematized nature on Rorsachach total response 9 (poor response rate). Pt has given 2 populars and 7 originals with punctuations 9 from level rating . Content analysis shows animal, human objects rejected cord 9.

IMPRESSION :

Patient with adequate cognitive function, with significant delusion, hence a delusion disorder cannot be ruled out.

DIAGNOSTIC FORMULATION :

42 yr old female with complaints of suspecting that her co-tenant is doing harm against her-2yrs, Suspecting that her house owner is loving her- 1 year 8 months, insidious onset, continuous & progressive course, Head injury 1yr back, suicide attempt 10yr back, with premorbid traits of extrovert, quarrelsome, not adjustable, religiousity. Alert, Ambulant, adequately dressed, in touch with surrounding, interested in interview, gaze contact made & sustained, rapport established, psycho motor activity-normal. SPEECH : QTR : normal, Reaction time : normal, Relevent & Coherent, Prosody maintained. THOUGHT : Form : Normal, Stream : Normal, Content : Delusion of persecution, Delusion of love, delusional misinterpretation. MOOD : Euthymic AFFECT : appropriate, congruent. PERCEPTION : No disturbance. HMF : Concsious, Attention & Concentration : Normally sustained, Oriented to time, place, person. Intelligence : intact. Judgement : intact. Insight : absent, Grade - I.

FINAL DIAGNOSIS :

ICD 10 – F22. 0 Delusional disorder

DSM IV -297. 1 Delusional disorders -Mixed

INVESTICATION :

COMPLETE HAEMOGRAM : Normal

V D R L	-	Non reactive
CXR	-	NAD
CT- BRAIN	-	Normal
EEG	-	Normal
Neurology opinion	-	Nil

MANAGEMENT :

1. Tab. Risperidone (2mg) 2-0-2
2. Tab. Chlorpromazine(100 mg) 1-0-2
3. Tab. Benzhexal(2mg) 1-1-1
4. Tab. Sodium valproate(200mg) 2-1-2
5. Tab. Diazepam(5mg) 0-0-1

Ing. Haloperidol(LA) 1ampule im once in three weeks

CASE - IV

Name	:	Mrs. A
Age	:	69yrs
Sex	:	Female
Marital status	:	Married
Religion	:	Hindu
Education	:	10th STD
Socio ecnomic	:	LSES
Informants	:	Daughter, younger brother
Information	:	Reliable, Adequate and consistent

REASONS FOR CONSULTATION:

Memory disturbance
Decrease in personal hygiene } one year, more for past 6 months
Sleep disturbance

Insidious onset, progressive course, no obvious precipitating factors

1ST psychiatric consultation

HISTORY OF PRESENT ILLNESS:

The patient was reported to be normal till one year back. Then, her daughter noticed that the patient repeatedly searched for certain things in the house. She would forget simple things in the house like the way for going to toilet. At times she also found it difficult to return to her house after going for a walk. In course of time, she was not able to identify her close relatives. She was not able to remember whether she had taken her food or not. Her personal hygiene decreased gradually. She did not take bath and did not dress properly. She would pass urine inside the house itself at times. She slept for very little time and would wake up in the middle of the night and keep pacing inside the house.Slowly she was not able to identify her own family members.

PAST HISTORY:

H/O Diabetes milletus 10 years, on irregular treatment.

No history of similar illness in the past.

No history of head injury, seizures or fever.

No history of Hypertension.

No history of substance use.

FAMILY HISTORY:

No history of mental illness, suicide or missing members in the family.

PERSONAL HISTORY:

Early childhood history is not available.

Born of consanguineous marriage.

Married at the age of 22 years.

Living with 1 daughter and 2 sons.

PERSONALITY TRAITS:

Adjustable and Easy going.

Tolerant to criticism, responsible.

Highly religious.She handled money and financial matters without others' help.

PHYSICAL EXAMINATION:

Thin built, not anemic, not jaundiced, no pedal edema.

Pulse -68/min

Bp -110/70

CVS-S1, S2 Heard.

RS-NVBS Heard.

Abdomen-Soft, No tenderness, No organomegaly

CNS – No focal neurological deficit

Funds - normal

MENTAL STATUS EXAMINATION:

General Appearance and Behavior:

Conscious, Ambulant, Rapport established with difficulty, not cooperative for interview, unkempt, no tics/ mannerisms.

Psychomotor Activity - increased.

Talk – She is not communicable, answered in monosyllables after asking simple questions at times.

Emotions: Mood – Irritable

Affect – Restless and irritable

Thought – No delusions.

Perceptions – no perceptual disturbances.

OTHER COGNITIVE FUNCTIONS:

Not oriented to time and place. Oriented to person.

Attention aroused with difficulty.

Concentration impaired.

Digit Forward, Digit Backward -0.

Memory – recent, remote and immediate memory are impaired.

Intelligence, abstraction and judgment could not be assessed as she could not comprehend the question.

Insight – Absent.

PROVISIONAL DIAGNOSIS:

F 00 Dementia in Alzheimer's disease

PSYCHOLOGICAL ASSESSMENT:

Mrs. A, who was provisionally diagnosed as a case of dementia, is taken up for psychological testing to establish the diagnosis and to assess the severity of illness.

TESTS ADMINISTERED AND THEIR RATIONALE:

1. **Mini Mental Status Examination** (MMSE) – It is a screening test to identify the organic etiology and also to assess the course of illness.
2. **Wechsler Memory Scale –** Used to assess his memory functions.

3. **Bender Gestalt test –** Used to assess the perceptual visuomotor functions.
4. **Brief Psychiatric Rating Scale –** Used to assess associated psychiatric problems.
5. **Seguin form board test –** A form perception test and also used as a test of intelligence
6. **Dementia Rating Scale –** Used to assess the severity of dementia.

BEHAVIORAL OBSERVATION:

The patient was made to sit in the chair by her sons and she frequently stood up during the interview. She was very much irritable and not cooperative for examination. Questions had to be repeated many times to get an answer.

Test result:

She obtained a very low score of 9 out of 30 in mini mental status examination showing a severe degree of impairment.

In Wechsler memory scale, she was not able to answer the questions because of poor concentration and on repeated questioning she answered irrelevantly. She was not able to draw a figure properly in

Bender Gestalt test. She simply scribbled over a paper which showed the organic nature of the disease and visuo motor disturbance.

Brief psychiatric rating scale revealed her uncooperativeness, psychomotor agitation, inappropriate affect and disorientation to time place all of which showed an organic nature and major psychiatric symptoms such as delusions and hallucinations were not present.

She could not perform Seguin form board test and she even could not understand the way to perform the test. Dementia rating scale revealed her inability to perform household tasks, inability to find ways, inability to recall recent events, not able to dress properly, purposeless hyperactivity and diminished emotional responsiveness all of which indicates a severe degree of impairment

SUMMARY:

There is marked impairment in her cognitive functions and visuol spatial perception.

There is also deterioration in personal hygiene and personality

FINAL DIAGNOSIS:

F 00 – Dementia in Alzheimer's disease

MANAGEMENT:

1. PHARMACOLOGICAL:

Cholinesterase inhibitors are useful. They potentiate the cholinergic neurotransmitter.

Very low doses of antipsychotics for behavioral problems.

2. BEHAVIORAL:

Family counseling to provide awareness to the family members about the guarded prognosis for this patient and the importance of rehabilitation.

Relatives were advised to give an understanding atmosphere to the patient and help her not to get confused.

Importance of proper follow-up is stressed to monitor the condition of patient and to help the family members in dealing with the patient adequately.

CASE - V

Name	:	Master. M
Age	:	18 yrs
Sex	:	Male
Education	:	3 rd STD
Socio economic status:		LSES
Back ground	:	Urban
Informant	:	Mother
Information	:	Reliable, Adequate and consistent

REASONS FOR CONSULATION:

Delayed developmental milestone

Scholastic backwardness — since childhood

Unable to acquire age appropriate skills

Not regular to work - 2 years

HISTORY OF PRESENTING ILLNESS:

Patient was born out of non consanguineous marriage, full term normal delivery. Mother was 22 yrs and fathers age was 298 yrs. No history of any drug intake, fever or exanthematous eruptions in the ante natal period. No ante natal checkup was done. No history of radiation, injury, malnutrition, or vaginal bleeding. Delivery was conducted by local dhai; h/o prolonged 2nd stage of labor, the baby cried soon after birth and was breast fed after a short while. No h/o neonatal seizures or difficulty in feeding. No h/o of jaundice, breast fed up to 10 months, and there were no weaning difficulties.

Milestones obtained are tabulated below:

	Milestones	**Age**
Motor	Head control	3-4 months
	Sitting with support	6-8 months
	Sitting without support	8 months
	Standing without support	1 year
	Walking by self	11/2 years
	Runing	3 years
Language	Babbling	4-5 months
	1 word	6 months
	2-3 words	3 years
	Named pictures	6 years
	Understood simple instructions	6 years
Personal& Social behaviour	Bldder and bowel control	6-8 years
	Dresses without assistance	8-10 years
	Playing with a group	8-10 years

PRESENT FUNCTIONING LEVEL:

The patient is able to take care of himself like bathing, dressing, eating without assistance, he goes to neighborhood shop and could carry out simple tasks of buying things but he frequently misses calculations. He takes care in dealing with fire, crossing roads etc.

PAST HITORY:

No overt features of psychiatric disturbances noted.

FAMILY HISTORY:

2nd of 3 siblings.

No h/o MR, Congenital anomalies in family.

No h/o seizures or any other illness in family.

PHYSICAL EXAMINATION:

General condition fair, well built, no pallor

Not jaundiced

Hypertelorism

Up slanting eyebrows

Depressed nasal bridges

PR- 78/min

BP – 110/70mmHg

CVS – S1, S2 heard no murmur

RS – NVBS, no added sounds

Abdomen- Soft, contender, no organomegaly

CNS – no FND. No neurocutaneous marker

Bilateral Findus – normal

MENTAL STATUS EXAMINATION:

General appearance and behavior –An alert, ambulant male who looks appropriate for his age entered the room on his own and took seat offered. Dressed adequately, well kempt. Gaze conduct sustained. Rapport could be established.

Talk – Quantum, Tone, Rate within normal limits. Relevant and Coherent
Mood –Euthymic

Thought – No formal thought disorder, content simple

No perceptual disturbances

PRIMARY MENTAL FUNCTIONS:

Oriented to time, place and person

Attention was aroused, but ill sustained

Concentration impaired

Memory immediate impaired, Recent, Remote –intact

General fund of information not adequate

Arithmetic ability – unable to do simple calculation

Judgment - intact

Grade II insight

PROVISIONAL DIAGNOSIS:

ICD- 10. F-70 Mental Retardation – Mild

PSYCHOLOGICAL ASSESSMENT:

Mr. M, 18 yrs old came with history of delayed developmental milestones and poor scholastic performance. He was taken up for psychological assessment to assess his intellectual functions and social functions.

TESTS ADMINISTERED AND RATIONALE:

1. **Seguin Form Board Test**: It is a test of forms perception and is used as a test of intelligence to get the baseline intellectual abilities.

2. **Benet Klamath Test of Intelligence (**BKT): It is a test of intelligence mostly based on verbal activities and reflects global intellectual abilities.

3. **Vinland Social Maturity Scale:** It is used to assess his social maturity level.

BEHAVIOURAL OBSERVATION:

He was co-operative for testing and had adequate interest in test situation.

TEST RESULTS:

Patient was very attentive and was able to concentrate for most of tests. His psychomotor activity was within normal limits. His Gestalt functions and concept formation of size, shape, and form were adequate, has a borderline knowledge about general information, was able to do simple arithmetic and carry out simple commands without any problems. His memory span is however decreased and in digit span test, he could not score more than 3. He has adequate knowledge about the value of currency.

He is functioning above 10 years line in his mental age as seen from Seguin form board test. In BKT his basal age was 5 years and terminal age

was 11 years with mental age around 8 years (5 years +36 months) giving rise to an IQ of around 50 placing him in mild degree of mental retardation His social functioning is about 10 - 12 years as rated from Vineland Social maturity scale. With his parent's report he is functioning around that age in self- help, general communication and socialization, locomotion and 8 years in occupation and 12 years in dressing.

SUMMARY:

He has sub average intellectual functioning. His IQ score of 50 places him in mild MR and his social maturity and acceptability shows that this individual can be well trained to earn his livelihood to some extent to help others in family.

FINAL DIAGNOSIS:

ICD – 10, F -70 Mental Retardation – Mild.

MANAGEMENT:

1. No medications are necessary as he has no psychomotor or behavioral problem.

2. He can be guided to various rehabilitation schools and training schools to teach him simple occupation with which he will be most benefited.